

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9216

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09225

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Wicomico</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Wicomico</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Yuma</i>	LENGTH OF STAY (in this place) <i>40 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Yuma</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH	
<i>Male</i>	<i>Alex</i>	<i>Sept. 13</i>	<i>1965</i>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED:	8. DATE OF BIRTH:
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>March 15, 1887</i>
9. AGE last birthday:	10. USUAL OCCUPATION (Give kind of work done during most of working life, if any):	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<i>67 5/28 yrs.</i>	<i>Farmer</i>	<i>Salisbury, md</i>	
13. FATHER'S NAME:	14. MOTHER'S MARRIED NAME:		
<i>John C. Bradford</i>	<i>Belle Malone</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
<i>No</i>	<i>None</i>	<i>Mr Wilcox E. Bradford, Salisbury, md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
153X IMMEDIATE CAUSE (A)			
<i>Carcinoma of Stomach-Related</i>			<i>?</i>
ANTECEDENT CAUSE (S) DUE TO			
<i>Carcinoma of Colon</i>			<i>?</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
<i>0</i>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 10, 1955</i> , to <i>Sept 13, 1955</i> , that I last saw the deceased alive on <i>Sept 13, 1955</i> , and that death occurred at <i>11:30</i> M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
<i>Thomas L. Jones, M.D.</i>		<i>Lucio Hill, Md.</i>	<i>9/15/55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>Sept 16, 55</i>	<i>Baltimore</i>	<i>Snow Hill, md</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR. ADDRESS	
<i>Sept 16, 55</i>	<i>Clayton E. Cooper</i>	<i>Clayton E. Cooper, Snow Hill, md</i>	

BUREAU V. S.

SEP 20 1955

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9217

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09226

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Route # 3				STREET ADDRESS (If rural give location) Route # 3		X	
3. NAME OF DECEASED: (First) (Middle) (Last) Charlotte Purnell Brittingham				4. DATE OF DEATH: (Month) (Day) (Year) 9 - 14 - 19 55			
5. SEX: Female		6. COLOR OR RACE: A. A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: 1896	
9. AGE last birthday: 59 yrs.		10. USUAL OCCUPATION, Give kind of work done during most of working life, even if retired: Domestic		11. BIRTHPLACE (State or foreign country): Berlin, Worcester Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Henry Henry				14. MOTHER'S MAIDEN NAME: Ellen Massey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Olivia Mayo, Berlin, Md. Rt. # 3			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
493X Immediate cause (a) Pneumonia Antecedent causes (s) (b) Diabetes mellitus Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)						8 days about 2 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 9-18-55				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-14-55 , to 9-14-55 , that I last saw the deceased alive on 9-14-55 , and that death occurred at 2:15 PM , from the causes and on the date stated above.							
SIGNATURE Larry H. Shuch, Jr.				DATE SIGNED Sept 17, 1955			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		9-18-55		Germentown, Cemetery		Berlin, Worcester Co., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
9-19-55		Helen F. Hayward		Mary G. Stewart, 324 E. Church St., Salisbury, Md.			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

• *Journal of Management Education* 31(1): 10-17

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09227

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
X TOWN <u>Berlin - Rural</u>	<u>25 yrs</u>	TOWN <u>Berlin - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>ETHEL</u>	(Middle)	(Last) <u>BRYDE</u>	(Month) <u>9</u> (Day) <u>28</u> (Year) <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 15 1867</u>
9. AGE last birthday: <u>87</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Shinsville, Arkansas</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10b. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Henry Bell</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Anna Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>No</u>	
17. INFORMANT & ADDRESS: <u>John V. Bryde</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
4221 Immediate cause (a) <u>Chronic Degenerative Myocarditis & Atherosclerosis</u>		2 yrs	
DUE TO			
Antecedent cause(s) (b) <u>Semirigid atherosclerosis & Coronary sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
stating underlying cause last (c) <u>Semirigid - Debility</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cardiac necrosis</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Norman Rabbie</u>		DATE SIGNED	
CHIEF MEDICAL EXAMINER			
DEPUTY MEDICAL EXAMINER			
ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>9/30/51</u>	
NAME OF CEMETERY OR CREMATORY: <u>Evergreen</u>		LOCATION (City, town, or county) (State): <u>Berlin Md.</u>	
DATE REC'D BY LOCAL REG. <u>9-30-55</u>		REGISTRAR'S SIGNATURE: <u>Helen F. Hayward</u>	
24. FUNERAL DIRECTOR: <u>Anna A. Conway</u>		ADDRESS: <u>Berlin Md.</u>	

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

OCT 5 1955

RECEIVED

9219

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Worcester		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R.F.D. # 2 Box 316		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke City,		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home				STREET ADDRESS (If rural give location) Pocomoke City, Md.		/	
3. NAME OF DECEASED: (First) Sallie (Middle) Collins (Last)		4. DATE OF DEATH: 9-26-1955		5. SEX: F.		6. COLOR OR RACE: C.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH: Feb. 17, 1890		9. AGE last birthday: 65 yrs.		10. MONTHS: Days: Hours: Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, e.g., retired, Housewife		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: George H. James		14. MOTHER'S MAIDEN NAME: Amelia ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: Ella James Pocomoke City, Md.		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION: 0		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH, 153X Immediate cause		(a) Carcinoma Colon		Interval Between Onset And Death 1 yr			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		(b) Anorexia + Wasting		2 mo			
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950, 19 to 9/26, 1955 that I last saw the deceased alive on 9/26, 1955 and that death occurred at 6 AM, from the causes and on the date stated above.		SIGNATURE Louis H. Clemely, M.D. (Degree or title)		ADDRESS Pocomoke City,		DATE SIGNED 9/28/55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 10/1/55		NAME OF CEMETERY OR CREMATORY Unionville, Md.		LOCATION (City, town, or county) (State) Pocomoke City, Md.	
DATE REC'D BY LOCAL REGISTRAR Oct 1, 1955		REGISTRAR'S SIGNATURE Anne E. White		24. FUNERAL DIRECTOR Edgar W. Hanton - New Church, Md.		ADDRESS	

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BUREAU V. 3

OCT 5 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Pocomoke City</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pocomoke City</u> 42			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>207 Walnut Street</u>				STREET ADDRESS (If rural give location) <u>207 Walnut Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Florence R. Cox</u>				<u>Sept 17 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>November 9, 1879</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>James R. Rowell</u>				14. MOTHER'S MAIDEN NAME: <u>Alice Hunnicutt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S ADDRESS: <u>Mrs. Fitzgerald Crockett Pocomoke City, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
204.1 IMMEDIATE CAUSE						<u>Myelogenous Leukemia</u> 6-7 mo.	
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>Arterio-sclerosis</u> 3-4 yrs	
						<u>Anoxia</u> 7 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1930</u> , 19 <u>55</u> , to <u>9/17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>55</u> , and that death occurred at <u>2A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Komis J. Flanely</u>				DATE SIGNED <u>9/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 19, 1955</u>		<u>Baptist Cemetery</u>		<u>Pocomoke City, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Sept. 19, 1955</u>		<u>Anne E. White</u>		<u>Henry H. Watson</u>		<u>Pocomoke, Maryland</u>	

MARGIN RESERVED FOR BINDING

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RECEIVED

BUREAU V. S.

SEP 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809230

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Worcester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
42 <u>Pocomoke</u>		<u>Life</u>		<u>Pocomoke</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>406 Second Street</u>				STREET ADDRESS (If rural give location) <u>406 Second Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>E. Clarke Fontaine</u>				<u>Sept. 10 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>October 12, 1879</u>	<u>75</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>State Supt of Schools (Md)</u>				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Edgar Fontaine</u>				<u>Alice C. Julian</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) -----				16. SOCIAL SECURITY NO			
<u>No</u>				<u>None</u>			
17. INFORMANT'S ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Mrs. Robert B. Harrison Williamsburg, Virginia</u>				I / DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
				IMMEDIATE CAUSE			
				ANTECEDENT CAUSE (S)			
				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
				(A) <u>Pulmonary Edema</u>			
				DUE TO			
				(B) <u>Cerebral Hemorrhage</u>			
				DUE TO			
				(C) <u>Degenerative Heart Disease</u>			
				<u>Chronic Glomerular Nephritis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>7 days</u>			
				<u>16 months</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLY NG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 4, 1949</u> to <u>Sept. 10, 1955</u> , that I last saw the deceased alive on <u>Sept. 10, 1955</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank W. Trader</u>				ADDRESS <u>M.D. Pocomoke City, Md</u>			
DATE SIGNED <u>Sept 12 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 13, 1955</u>		<u>Presbyterian Cemetery</u>		<u>Pocomoke City, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<u>Sept 13, 1955</u>		<u>Anne E. White</u>		<u>Henry H. Watson, Pocomoke, Maryland</u>			

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9220 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09231
CERTIFICATE OF DEATH

Reg. Dist. No. 955

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Berlin</i>		<i>6 yrs</i>		OR TOWN <i>Berlin</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>R 52</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>FRYMON PYLYPCZUK</i>				<i>Sept. 14 1955</i>			
5. SEX: <i>MALE</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE. MARRIED. WIDOWED, DIVORCED. <i>married</i>		8. DATE OF BIRTH: <i>Nov. 14, 1890</i>	
				9. AGE last birthday: <i>64 yrs</i>		10. UNDER 1 YEAR 11. UNDER 24 HRS. 12. CITIZEN OF WHAT COUNTRY? <i>UKRAINE</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Farm</i>		11. BIRTHPLACE (State or foreign country): <i>UKRAINE</i>		12. CITIZEN OF WHAT COUNTRY? <i>UKRAINE</i>	
13. FATHER'S NAME: <i>ORSHANTYJ PYLYPCZUK</i>				14. MOTHER'S MAIDEN NAME: <i>PARASZKA SZUSKO</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <i>Mr. MICHAEL PYLYPCZUK, BERLIN MD</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X IMMEDIATE CAUSE (A) <i>Carcinoma of Head & Pancreas & Metastasis</i>							
ANTECEDENT CAUSE (B) <i>to liver, brain, lungs.</i>						3 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>See "cancer" due to above - 1st seen March 3, 1955</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>15 Jan.</i> , 1955, to <i>16 Sept.</i> , 1955, that I last saw the deceased alive on <i>15 Sept.</i> , 1955, and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Herman A. Rabl</i>		ADDRESS <i>Berlin, Md</i>		DATE SIGNED <i>9/16/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>9/17/55</i>		<i>St. Pauls</i>		<i>Berlin Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>9-19-55</i>		REGISTRAR'S SIGNATURE <i>Helen F Hayward</i>		24. FUNERAL DIRECTOR <i>Burton D. Burby</i>		ADDRESS <i>Berlin Md</i>	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

9221

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09232

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Worcester</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Snow Hill</i>		<i>1 yr 3 mo</i>		TOWN <i>Snow Hill</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <i>Chal</i> (Middle) <i>F.</i> (Last) <i>Smullen</i>				OF DEATH <i>Sept 2 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH:	
				<i>Married</i>		<i>Nov. 15 - 1908</i>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<i>46</i>		<i>9/17 yrs</i>		<i>Months Days Hours Min.</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>Housewife</i>				<i>Own home</i>		<i>Canada</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>George Honeyswell</i>				<i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:	
<i>no</i>				<i>214-28-2136</i>		<i>Mrs. Gladys Whitlock Rural #2</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <i>Cachexia and inanition</i>			
ANTECEDENT CAUSE (B)				DUE TO <i>4 wks</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <i>Metastatic Carcinoma of the Breast</i>			
				DUE TO <i>12 mos.</i>			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>Aug 6, 1954</i>				<i>Carcinoma Right Breast (Mastectomy)</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 15, 1954</i> , to <i>Sept. 2, 1955</i> , that I last saw the deceased alive on <i>Sept. 1, 1955</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J. Smith, Lamar</i>				DATE SIGNED <i>9-2-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>				<i>Sept 5/55</i>		<i>St. Luke's</i>	
24. DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
<i>Sept 5, 55</i>				<i>Clayton E. Cooper</i>		<i>Wm. B. Dimmick, Snow Hill, Md</i>	

BURMAN V. S.

SEP 7

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09233

9222

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i>		LENGTH OF STAY (in this place) <i>38 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i>			
TOWN <i>Girdletree</i>				TOWN <i>Girdletree</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>02</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>Sarah</i> (Middle) <i>Snead</i> (Last) <i>Snead</i>				4. DATE (Month) <i>Sept.</i> (Day) <i>23</i> (Year) <i>1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>Caucasian</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Married</i>		8. DATE OF BIRTH: <i>March 15/1917</i>	
9. AGE last birthday: <i>38 6/8</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Domestic</i>		11. BIRTHPLACE (State or foreign country): <i>Girdletree, md</i>		12. CITIZEN OF WHAT COUNTRY? <i>md</i>	
13. FATHER'S NAME: <i>John Jackson</i>				14. MOTHER'S MAIDEN NAME: <i>Bulah Wier</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS: <i>M. Abie Snead, Girdletree, md</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Cardiac Failure</i>						?	
ANTECEDENT CAUSE (S) DUE TO <i>Bronchial Asthma</i>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept. 23, 1955</i> , to <i>Sept. 23, 1955</i> , that I last saw the deceased alive on <i>Sept. 23, 1955</i> , and that death occurred at <i>3:40</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Thomas L. Jones, M.D.</i>				ADDRESS <i>Snow Hill, Md.</i>		DATE SIGNED <i>9/23/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept. 27/55</i>		NAME OF CEMETERY OR CREMATORY <i>Coalgroves</i>		LOCATION (City, town, or county) (State) <i>Girdletree, md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Sept 27/55</i>		REGISTRAR'S SIGNATURE <i>Clayton C. Cooper</i>		24. FUNERAL DIRECTOR <i>Samuel Hill, md</i>		ADDRESS	

BUREAU V. 2

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09234

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Worcester</u>	MARYLAND	STATE <u>Ind</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bishopville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishopville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Infant</u> <u>Webb</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Sept. 15</u> 19 <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>Sept. 15, 1955</u>
9. AGE last birthday: <u>9 mo</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Bishopville Ind</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Virgil Webb</u>	
14. MOTHER'S MAIDEN NAME: <u>Katherine L. Mitchell</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>9</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>Mr. Virgil Webb, Bishopville Ind.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Asphyxia neonatorum</u>			
ANTECEDENT CAUSE (B) <u>Cerebral anoxia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE <u>Robert G. Shults</u>		M. D. <u>Berlin, Md.</u> DATE SIGNED <u>9/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Red Mens Cem.</u>		LOCATION (City, town, or county) (State) <u>Beltsville Del</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9-17-55</u>		24. FUNERAL DIRECTOR <u>Prima D. Burby</u> ADDRESS <u>Berlin Md.</u>	

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